Medical Assistance Hospital Provider Agreement

(See instructions on back)

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE • DEPARTMENT OF FINANCE AND SUPPORT

1. Check Type of Request b. ❑ New FTIN Number
a. ❑ New Provider No. c. ❑ Update Expired Provider Number

2. Federal Employer I.D. Number (If new Federal I.D., list date issued)

Federal I.D. No. Issued To Date Issued

d. Current 11-Digit Provider Number

PROVIDER NAME AND ADDRESS	**PAY TO NAME AND ADDRESS (if different from 3)**
3. Full Name	4. Name
Street Address (Physical Location)	Mailing Address
City State Zip	City State Zip
Telephone No. ( )	Telephone No. ( )

5. Type of Payee: (Check one)
1 ❑ City 3 ❑ District 5 ❑ Federal 7 ❑ Individual, Partnership, Corporation-Proprietary
2 ❑ County 4 ❑ State 6 ❑ Voluntary Non-Profit - Non-Proprietary

6. Fiscal Year End	7. License Number	8. Medicare Number (If applicable) (Medicare No. or NPI No.)

9. Class of Care and Number of Certified Beds (Be sure to state number of certified beds in categories below)

❑ Acute Inpatient No_____ ❑ Psych Inpatient No_____ ❑ Dialysis
❑ Bassinet No_____ ❑ Psych Outpatient ❑ Other (Specify)_____
❑ General Outpatient ❑ Psych Day Treatment
❑ Rehab Inpatient No_____ ❑ Psych Residential (RTC)

10. Check if the facility listed on this agreement has been suspended or terminated from any government medical program:
❑ Yes ❑ No If Yes - Date:_____ Reason:_____

MEDICAID USE ONLY

Acute Inpatient _____	Peer Group _____	Effective Date _____
Psych Inpatient _____	Peer Group _____	Effective Date _____
Rehab Inpatient _____	Peer Group _____	Effective Date _____
Outpatient _____	Peer Group _____	Effective Date _____

TERMS OF AGREEMENT

I agree to participate as a provider in the Nebraska Medical Assistance Program, and assure the Nebraska Health and Human Services System:

* That the policies and procedures of the Nebraska Health and Human Services System in the administration of the Nebraska Medical Assistance Program will be followed.
* That the payment determined in accordance with the policies of the Nebraska Health and Human Services System will be the full and complete payment for the services provided and the amount paid by the Medical Assistance program for those claims submitted by me or my authorized representative will be accepted as payment in full and that no additional payment will be claimed. If any additional payment is received, or will be received, from any other source, that amount will be deducted from the amount charged the Department; and any payment, from another source that is received after payment by the Department shall be remitted to the Department.
* That all goods and services for which payment will be claimed will be provided in compliance with the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (45 CFR, Parts 80, 84, and 90).
* That I will keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Nebraska Medical Assistance program (42 CFR 431.107).
* That the authorized representatives of the Nebraska Health and Human Services System, Federal Health and Human Services, and the Federal and State Fraud and Abuse Units will be afforded the right to review and/or receive copies of my Medical Assistance client/patient records to substantiate claims submitted by me to the Department upon receipt of a proper patient waiver. A client's/patient's signed Medical Assistance Application includes a proper patient waiver (42 CFR 431.107).
* That enrolling in NMAP does not constitute employment by the State of Nebraska.
* That all information will be disclosed to Nebraska Health and Human Services System as required by policies of NMAP.
* That any false claims (including claims submitted electronically), statements, documents or concealment of material fact may be prosecuted under applicable State or Federal laws (42 CFR 455.18).

I certify the information on this form is true, accurate and complete.

II. SIGN HERE _____

Signature of Provider/Authorized Representative/Agent and Title (Stamped Signature **NOT** Accepted) Date Phone Number

DISTRIBUTION: Return ORIGINAL to Nebraska Health and Human Services System, Finance and Support, Provider Enrollment, P.O. Box 95026, Lincoln, NE 68509-5026;

It is the provider's responsibility to retain a copy of the completed Agreement.

471-000-91 Form MC-20, "Medical Assistance Hospital Provider Agreement" and Completion Instructions

Use: Form MC-20, "Medical Assistance Hospital provider Agreement", is used for -

1. The required agreement for the Nebraska Medical Assistance Program hospital and dialysis center providers; and
2. The computer input document to establish each provider's computer files for payment.

Completion: The provider or the provider's authorized representative must complete Form MC-20 as follows:

Please type or print legibly.

1. Check Type of Enrollment Request:

   a. Check "New Provider Number" if you do NOT currently have a Nebraska Medicaid provider number; or
   b. Check "New FTIN Number" if you have a provider number and you are requesting another provider number because your Federal Tax Identification Number (FTIN) has changed; or
   c. Check "Update Expired Provider Number" if your Nebraska Medicaid provider number has expired. Note: Change of address, number of certified beds, etc. can be faxed to 402-471-8703 or a letter can be sent to the address below.
   d. Enter current Nebraska provider number, if applicable.

2. Enter the FTIN of the provider requesting enrollment. Enter the NAME to whom the FTIN was issued. Enter the DATE the FTIN was issued, if available.

3. Enter the full name of the facility. Enter the physical location address, city, state, zip code, and telephone number. Note: A post office box without a physical location address will not be accepted.

4. Complete only if payment will be made to a name and/or address other than identified in Field 3. Note: A post office box is acceptable in this field.

5. Check appropriate box for type of payee.

6. Enter the facility's fiscal year-end date. Change of fiscal year end date can be faxed at 402-471-8703 or a letter can be sent to the address below.

7. Enter the hospital's license number, if applicable.

8. Enter the hospital's Medicare number or National Provider Identifier (NPI) number.

9. Check the appropriate categories of service the facility provides and indicate the number of certified beds for each category. Note: More than one category can be checked for mental health services. Check only one box for Acute, Rehab, or Dialysis. Separate provider numbers are required for each of these categories.

10. Check Yes or No. If yes, provide the effective date of suspension/termination and indicate the reason.

11. The facility's authorized agent must sign and date the Provider Agreement certifying that the information is true, accurate, and complete. A stamped signature will not be accepted. Enter the telephone number.

Note: **If information provided on this form changes**, contact the Nebraska Department of Health and Human Services Finance and Support, Medicaid Inquiry at (877) 255-3092 or 471-9128 in Lincoln or Medicaid Provider Enrollment at (402) 471-3121.

Note: Failure to complete and sign this form and/or any requested updates is grounds to deny enrollment or to terminate any existing provider agreements under the Nebraska Medical Assistance Program.

Note: Incomplete agreements will be returned.

Distribution: Return original agreement to Nebraska Department of Health and Human Services Finance and Support Medicaid Provider Enrollment, PO Box 95026, Lincoln, NE 68509-5026. It is the provider's responsibility to retain a copy of the completed Agreement.